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ASHA

Journal of the American Speech and Hearing Association

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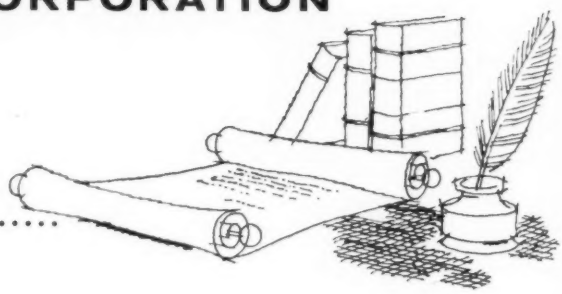

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Asha

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CONTENTS

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SPEECH PATHOLOGY AND AUDIOLOGY

RAYMOND CARHART*
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INTRODUCTORY NOTE: Early last year, the American Medical Association's Joint Committee to study the Relationships of Medicine with Allied Health Professions and Services invited representatives of a number of professional associations to attend a two-day meeting to discuss areas of mutual concern and to explore means for closer liaison among professions participating in medical education, research and the care of the patient. Representatives were present from the fields of Biochemistry, Microbiology, Pharmacology, Physiology, Psychology, Public Health Laboratories, Speech Pathology and Audiology, Laboratory Services, Pathology, Physical Medicine, Psychiatry, and Radiology. The American Speech and Hearing Association was represented by Raymond Carhart and Kenneth O. Johnson. The following statement is a resumé of the comments prepared and presented by Dr. Carhart.—*Editor*

GENTLEMEN: There is much in common between the professional fields we have already heard described and the area of Speech Pathology and Audiology. For example, this latter area is highly analogous in its academic orientation and in its research scope to Psychology and to Physiology. There are similar parallels to the other disciplines which have been discussed.

However, it is through mention of contrasts that the field of Communicative Disorders can be most usefully reviewed today. These contrasts highlight the features which are critical in understanding the interactions between medical practice and clinical activities in speech pathology, language pathology and audiology.

A major point of contrast to Medicine is that the clinical management of communicative disorders is a new discipline. The first Ph.D.'s in this specialty were not awarded until the 1920's—and these, interestingly enough, were granted through divisions of Liberal Arts. The relationships between Communicative Disorders and medical science have been evolving since then, but it is understandable that substantial misconceptions still exist as to these relationships. An important feature of the situation is that the process of clarification will continue for some time because the field of Communicative Disorders is still solidifying. The scope of its substantive knowledge is becoming broader and the boundaries of its clinical activity are becoming clearer as it continues to mature. However, the critical fact is that he field of clinical Communicative Disorders has emerged as a well-defined segment of modern human endeavor.

It is necessary, in presenting a picture of this new field in a few minutes to be content with a brief discussion of four generalizations regarding its purposes and current status. These four generalizations are:

1. An independent and self-directed specialty for coping with communicative disorders exists.
2. The management of communicative disorders is primarily educational rather than medical.
3. Although this specialty is non-medical, it has developed techniques that supply information which the physician finds useful in diagnosis and in planning patient care.
4. Since this specialty can often perform its task most effectively when housed in a medical environment, the nurturing of proper inter-professional relations is imperative.

AN INDEPENDENT EDUCATIONAL FIELD

Consider first the fact that the field of communicative disorders is primarily educational rather than medical. This feature is true both historically, since speech pathology and audiology evolved from the Arts and Science segment of the academic world, and operationally, since the speech pathologist and audiologist are not concerned with the same kinds of human problems that face the physician. Speech pathologists and audiologists do not have professional responsibility for the health and physical welfare of people. They do not deal with matters of life and death. Instead, they deal, purely and simply, with human beings as social entities. They are concerned with their skills for interaction with other persons. Thus, the communicative act is the point of special focus for the audiologist, the speech pathologist, and the language pathologist.

This last statement deserves amplification. The scientific orientation from which the audiologist, the language pathologist or the speech pathologist approach all problems is one of understanding the processes of normal communication. He must, for example, know the nature of speech as an acoustic entity, as a neuromuscular entity, and as a symbolic entity. He must

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also appreciate the role of audition in the communicative cycle. Again, he must understand the internal language functions of the normal human being. And so on.

Obviously, if there were never any breakdowns in the transmission of human thoughts and feelings, the field of communicative disorders would have no reason for existing, except as a strictly academic subject matter. However, myriad breakdowns occur—so that corrective attention must be given to the personal problems they produce. Quite frequently, but not always, these breakdowns are the result of physical lesion, structural abnormality, or pathology. It is here that the fields of Medicine and Communicative Disorders meet. The two fields share common concern for persons whose physical ills or defects interfere with speech, with language manipulation, or with hearing. The critical point is that the two fields meet to accomplish completely different tasks.

The goal of Medicine is to restore health and to enhance physiological function insofar as possible. The crux of the physician's responsibility is captured in the phrase "patient care." By contrast, the goal of the field of Communicative Disorders is to teach people to achieve as great efficiency as possible in their own acts of speaking and hearing. The purpose is to alleviate thereby the handicaps to social adjustment which these people would otherwise experience. The fact to be remembered is that, although each field encourages the achievement of both sets of goals, the development of communicative skills is not an extension of medical treatment. It is an entirely different kind of endeavor.

Consider, for example, the deaf child. His physical problem must be understood and met, but his communicative needs include more than the requirement that he learn how to say words like "ball." *He must also learn that words exist* and that one of them stands for round, bouncy objects. Consider also the child with cleft palate. His physiological capacities are determined by his oral and velar structures and by the surgery which is practical in his case. However, his ability to speak clearly depends also upon a laborious process of training directed simultaneously toward mastering new skill and toward eliminating the faulty habits of controlling his speech mechanism which he has unwittingly acquired. Lastly, consider the aphasic adult. His neurological damage must be defined and, insofar as possible, alleviated by medical science. However, the most effective restoration of his language functions require insightful re-education of his symbolic processes.

Re-phrasing the matter, the areas of speech pathology, language pathology, and audiology have evolved as independent and self-directed specialties in consequence of their distinctive responsibilities to humanity. The emergence of these specialties has been recognized by numerous physicians and medical groups throughout the nation. Because of this recognition, highly efficient programs for dealing with communicative disorders have developed in many hospitals and other medical institutions even though these functions are not essential to the preservation of life or to the restoration of physical well-being.

There are two reasons for encouraging the development of such programs in medical settings. The first reason is that a smooth transition from medical to post-medical management of the patients can thus be achieved. The second reason is that speech pathologists and audiologists also perform special services which yield information that the physician finds valuable. These services furnish data that he can integrate with other findings in reaching his diagnoses and his decisions regarding treatment. Audiological tests, for example, supply facts which help the otologist reach his opinion as to whether an industrial worker is falsifying an auditory impairment or whether he has an organic involvement. Such special services require unique knowledge and skill which, again, are not a direct part of patient care. A significant point is that, important as such services be, they are from the speech pathologist's and audiologist's points of view secondary to their task of dealing with interpersonal handicaps arising from hearing, language, and speech defects.

PROFESSIONAL ACTIVITY

One way of exemplifying the current scope of the field of clinical communicative disorders to examine the kinds of positions held by a typical group of specialists in this field. Consider as an illustration, because I happen to be particularly familiar with the group, the sixty-three recipients of the Ph.D. degree from the Department of Communicative Disorders at Northwestern University. Remember as you contemplate the facts regarding this group that Northwestern University is only one of eight universities in the Big Ten that have been granting the doctorate in this field and that the Big Ten is only partially representative of even the Midwest.

Most of the 63 persons in the sample we are reviewing received their Ph.D. degrees since 1950. The group is distributed in 26 states and one foreign country. Seventy-five per cent hold academic appointments on teaching faculties. Seven out of every 10 in these academic positions have ranks of associate professor or better. Forty-six per cent of the entire group are affiliated with medical institutions, while 43% are affiliated only with nonmedical institutions. Fifty-four per cent have major administrative responsibilities. Five out of every 11 having such responsibilities are in medical institutions.

It is significant that even though only a fraction of the persons under discussion function in the medical environment, almost a quarter of the entire number administer independent programs within medical schools and hospitals. This fact is evidence of the capacity for self-directed professional service which the field of clinical communicative disorders has demonstrated. Thus, speech pathology, language pathology, and audiology have already emerged as areas which are *not* paramedical in the sense implied by the statement that ". . . all paramedical personnel should work under the supervision of physicians, serving as the hands of physicians and not as independent agents" (1). The jobs of the speech pathologist and audiologist are basically different from that of the

physician and, hence, the foregoing statement is not relevant.

LIAISON WITH MEDICINE INCREASING

Expressed differently, consider the matter in terms of the wording of the Progress Report of the Joint Committee to Study Paramedical Areas in Relation to Medicine. This report remarks that some paramedical groups ". . . have tended to move away from medical groups and establish themselves separately." (2) The situation in speech pathology, language pathology, and audiology is the direct opposite. These areas developed originally as autonomous academic fields with their roots in Arts and Science, but they accepted the responsibility to alleviate communicative handicaps. These areas have since been moving continuously toward cohesive liaison with Medicine. Speech pathologists and audiologists are glad that such is the case, and they are anxious to further the process.

Many medical men have been equally quick to encourage professional interplay. As mentioned earlier, there are many fine examples at the local level of integration between the two fields. In these instances, the speech pathologist and audiologist are rigorously insistent that their cases receive full medical management, while the physician relies on them to plan and to conduct the nonmedical program in speech and hearing.

Nonetheless, the national picture is still somewhat chaotic. There are localities where insightful liaison has not developed. Most disturbingly, there is a major misunderstanding with one specialty within the medical profession; namely, Physical Medicine. The physiatrist lays claim to the communicative field, even though his training does not equip him to cope with the educative problems in this area. Thus, Physical Medicine stands in sharp contrast with Otoloryngology, Neurology, Psychiatry, Pediatrics, and Gereontology—all of which have given many evidences of awareness that the field of clinical communicative disorders performs educative rather than treatment tasks. Consequently, members of these latter specialties are the ones who have developed with speech pathologists and audiologists cooperative programs which offer patients optimal balance of medical treatment and socio-communicative management. It is sincerely to be hoped that a similar understanding can be achieved with Physical Medicine.

BOUNDARY CLARIFICATION NEEDED

All concerned can help to achieve this understanding by differentiating the respective purposes of the two fields and by establishing clear demarcations of the boundaries which distinguish them. In particular, the roles of the speech pathologist and audiologist will be greatly clarified when the national organizations in both fields jointly formulate statements and policies that are realistic to the situation. When such a development occurs, the two fields will achieve at the national level the kind of harmonious interaction which has been so well exemplified in many local situations.

One of the most important ways of encouraging nationwide harmony is for both professional fields to support a program for officially recognizing those individuals who are qualified to deal with communicative disorders. In other words, a good system of certification is essential so that physicians, speech pathologists and audiologists, members of other professional groups, and the public can identify the competent speech pathologist, language pathologist, and audiologist.

ASHA CERTIFICATION

The American Speech and Hearing Association has a certification program which meets this need and which consequently deserves support by the American Medical Association. This program, which is being continuously improved, has been in operation since 1942. It is based on the axiom that proper training and experience, rather than any particular academic degree, is critical in coping with communicative disorders. Thus, certification is open to all who qualify as skilled speech pathologists, language pathologists, or audiologists. Obviously, the physician who has appropriate interests and background is welcome to certification if he desires it.

The certification program itself is simple in broad detail. Two levels of accomplishment are currently recognized. The first level is Basic Certification. Here the requirements are possession of the bachelor's degree with one year of specialized course work, clinical practicum and a year of professional experience. The person who satisfies these requirements is judged competent to work professionally when he is under supervision of a person holding the higher level of certification. This higher level, known as Advanced Certification, requires an additional year of academic training, further practicum, and three more years of full-time professional experience. As it turns out, persons who meet these latter requirements hold at least the Master's degree and many have the Ph.D. or its equivalent. However, the American Speech and Hearing Association awards Advanced Certification only to individuals whom it judges as qualified to make independent professional decisions, to supervise holders of Basic Certification, and otherwise to function autonomously in their chosen area of speech pathology and audiology.

A still higher level of certification, the Diplomate status, is in process of being established. Here the requirements will undoubtedly be the Ph.D. or its equivalent, appropriate advanced training and experience, and direct demonstration of advanced professional skills. These requirements will be sufficiently stringent to demark the Diplomate clearly from persons with Advanced Certification, who will continue to be recognized as competent to direct their own professional activities.

As the foregoing summary indicates, the American Speech and Hearing Association has taken the initiative in establishing the requirements and in conducting the program for certifying clinical personnel in speech pathology, language pathology, and audiology. This program has proved its effectiveness. It deserves

the support of the American Medical Association and other medical groups. Such support will encourage more effective inter-professional liaison both nationally and locally. It will help physicians and public both to recognize competent services in the fields of speech pathology and audiology. The ultimate gain to all which will accrue from utilizing these services is obvious.

CONCLUSION

In closing, it is important to reiterate that the field of communicative disorders has evolved from non-medical fields and that it has always integrated contributions from many disciplines. Persons who do not fully appreciate these facts sometimes draw false and unfortunate comparisons. There is an erroneous tendency to classify speech pathologists and audiologists who do not hold the doctorate as technicians. In truth, *there is no analogy between these individuals and the various therapy technicians who function under Physical Medicine.* Speech pathologists, language pathologists, and audiologists are trained as analysts of the processes of speech and hearing, as teachers of communicative skills and as re-educators of these skills—not as technical participants in a medical task. Actually, most speech pathologists and audiologists who do not hold the doctorate are employed in public schools. They get extra pay and recognition because they are performing an unusual task for American education. They exercise the independence of judgment and of initiative which is the basic perogative of every teacher. Thus, the B.A. or the M.A. in Speech or in Hearing must be viewed as analogous to the B.A. or M.A. in Mathematics, Biology, or English. The demonstrable fact is that thousands of the people in the speech and hearing area possess this status—and that these people are the core of the professional fields of speech pathology, language pathology, and audiology.

The medical profession must recognize the implications of this last fact. It is gratifying that some speech pathologists and audiologists are making their skills available in hospitals, in rehabilitation centers, and in medical clinics. However, these individuals are the minority within their own profession. Moreover, their skills can be properly utilized only if the unique nature of these skills is fully recognized. The most effective inter-professional liaison will be achieved if all concerned remember that the speech pathologist, the language pathologist and the audiologist deal with the social and educational aspects of communicative needs and breakdowns. Of course, it must never be forgotten that the medical environment is an exceptionally fine place to deal with many of these needs—provided everyone has the insight to allow the field of clinical communicative disorders the autonomy it warrants.

References

1. Resolution #12. Licensure of Paramedical Groups. *Proceedings of the House of Delegates, American Medical Association, Minneapolis. Dec. 2-4, 1958.* Chicago: American Medical Association, 1959, p. 121.
2. *Ibid.*, p. 59.

Legislation

During the past six six months our Association and its membership have been busily engaged in presenting information to legislators throughout the United States regarding the pressing needs we are facing in the fields of speech and hearing. Recent articles in Asha *have indicated that the implications for our field and the handicapped population we serve are extremely great with the eventual passage into law of such resolutions as Senate Joint Resolution 127 and House Joint Resolution 494.*

In general, our publications have dealt mainly with Title II of these Resolutions having to do with the Training of Speech Pathologists and Audiologists. Clearly, Title I, the Training of Teachers of the Deaf section of this resolution should also receive our active support.

In an effort to give our membership a greater understanding and feeling for the problems facing training establishment and educators in the field of the deaf, we are taking this opportunity to publish the following testimony which was given by George T. Pratt, Principal, and Fred D. Knittle, Director of Development, The Clarke School for the Deaf in Northampton, Massachusetts. These statements were presented to the Subcommittee on Special Education of the United States House of Representatives Committee on Education and Labor at a public hearing held at New Haven, Connecticut on December 17, 1959.—Editor.

TESTIMONY GIVEN BY GEORGE T. PRATT, M.Ed, L.H.D.*

Mr. Elliott and Members of the Committee:

Thank you for your invitation to me to offer testimony with regard to House Joint Resolution 494, introduced by Mr. Elliott, and its companion resolutions 488, 503, 507, 512, 516, and 526 presently under consideration by your committee. I strongly support the resolution and urge an early and favorable recommendation by your committee. This is the position taken by The Conference of Executives of American Schools for the Deaf, The Alexander Graham Bell Association for the Deaf, and The Convention of American Instructors of the Deaf which are the three national organizations representing our profession across the country.

The formal education of a deaf child is a highly specialized field and a particularly difficult one. Coming to us without the ability to speak, to understand speech, to read or to write, he requires special educational procedures which are designed to help him compensate for his hearing loss. He must achieve facility with language, in both its receptive and expressive forms, if he is to fulfil his potential as a human being.

The odds against him seemed to be such that for 210 years following the settlement of Jamestown there was no organized educational program for him in this country. From the establishment of the American School in 1817 until the present great strides have been made on behalf of the deaf. There are now 365 schools and classes for deaf children in the United States serving some 30,000 students. There are approximately 4,000 teachers of the deaf. Not one of us is satisfied with our present accomplishments, educationally or administratively, and we are anxious to progress.

Love, affection, and compassion make life more agreeable for the deaf child, but these alone are not enough to open up the doors of opportunity and fulfilment. The professional knowledge and skill of specially trained classroom teachers of the deaf is essential.

What are some of the areas in which classroom teachers of the deaf require special training?

(1) *Speech:* How to teach a deaf child to produce speech which is intelligible to his hearing contemporaries when he can hear neither the speech of others to imitate nor his own efforts to speak.

(2) *Language:* How to teach a deaf child the flow of connected language including word sequence of accepted usage, tense, agreement of subject and verb, pronouns, etc. ad infinitum, when he does not hear the spoken

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word. Consider the struggle of hearing children with spoken and written language even though they are constantly exposed to it from birth.

(3) *Curriculum:* How to organize and present learning experiences and subject matter to deaf children that they may acquire the basic fundamentals which will enable them to learn and explore independently.

(4) *Auditory Training:* How to exploit the residual hearing which most deaf children possess through modern amplification equipment. In addition to assisting with lipreading, this helps in contending with the feeling of "aloneness," peculiar to deafness, and contributes toward a sense of being a part of the world as well as being in it.

(5) *Psychology:* How does the lack of hearing experience affect the thinking, responses, and attitude of deaf children and adults?

(6) *Observation and Practice Teaching:* Daily contact with deaf children in well graded classes over an extended period of time under the guidance and supervision of experienced teachers is necessary in training teachers of the deaf.

There are other special courses which teachers-in-training must take to meet minimum certification requirements recognized by our profession. At least one full academic year of special training is necessary to prepare oneself to teach deaf children.

There is an acute nation-wide shortage of trained classroom teachers of the deaf. This has been substantiated by a study conducted this year by Johnston and Frisina, the facts and conclusions of which will be introduced into this hearing by Mr. Fred D. Knittle who has been designated by the Conference of Executives of American Schools for the Deaf to speak for that organization. Over the past ten years I have attended many of our professional meetings and heard papers and panels given at each directed to the problem of the teacher shortage. The net tangible result seems to have been a steady worsening of the situation.

A basic problem of finances is involved. After students have completed 12 years of elementary and high school, then committed their families to the expense of college or university, it is natural for them to want financial independence and to proceed at once to accept employment. Many college students may have an active interest in preparing themselves to teach deaf children, but feel they cannot ask their parents to support them financially during the training period required. Thus our profession loses teachers and future leaders.

This national shortage of classroom teachers of the deaf began during World War I and has persisted until today, becoming more acute year by year. Its effects are detrimental no matter how schools for the deaf may have attempted to accommodate themselves to it: (1) by admitting fewer children; (2) by enlarging the number of children in classes; or (3) by employing untrained teachers and attempting an "in-service" training program.

The limited numbers of students flowing into our training centers has persisted so long that our profession now faces further significant difficulties which are directly associated with the basic shortage. Schools are not able to find supervising teachers, principals, or superintendents to administer educational programs. During the past five years we have received letter after letter asking us to recommend persons for highly responsible, and well paid, positions but good people are already holding positions of leadership and do not wish to change. Directors of our research departments have not been able to develop enough young scientists who are interested directly in our special field to mount a truly substantial research effort. Even though the many ramifications of deafness present the most stimulating and challenging possibilities, research grants to our special field have been meager. It is becoming increasingly difficult to staff the training centers themselves.

The problem we are outlining here lies at the heart of our profession, and the situation is critical. If the provisions of this resolution were to go into effect immediately it would take us ten years at least to catch up. We urge you, with all sincerity, to place House Joint Resolution 494 high on your agenda for consideration when Congress reconvenes in January. Early favorable action will make it possible for us to try to fill our training centers with students for the school year beginning in September 1960. Recruiting reaches its peak in February and March.

TESTIMONY GIVEN BY FRED D. KNITTLE*

MR. ELLIOT and Members of the Committee:

It is a distinct pleasure to appear here today to read into the record of this hearing a few important facts pertaining to the critical shortage of classroom teachers of the deaf. My relationship to this special field of education has been of relatively short duration. In replacing Mr. Evan Johnson as Director of Development at The Clarke School for the Deaf, I have assumed his role as a spokesman for the Conference of Executives of American Schools for the Deaf. I have become increasingly aware of this growing need and can appreciate the problems faced by the leaders in this field.

In the few short months since House Joint Resolution 494 and its counterparts were introduced, we have received numerous letters from educators, parents and friends from all over the United States, stating their great interest in this bill and their sincere desire to see its early passage. They join with me in support of this resolution.

No one knows exactly how many people in the United States are deaf. It has been estimated that as many as 15 million people have some loss of hearing and that eight million of these suffer a loss sufficient to warrant the use of a hearing aid. Many people with hearing losses can be helped by medical, surgical or mechanical means to regain their hearing or, at least, to compensate for it. There are, however, about 200,000 people who are truly deaf; that is, they can not recognize sound as we know it. Only through intensive training in a highly specialized Program and in the use of the small amount of residual hearing they may have can they compensate for this loss.

Modern medicine has done much to overcome many disabilities in children. But, at the present time, education, not medicine, provides the major hope for the deaf child. There are today nearly 30,000 children enrolled in 365 schools and classes for the deaf in the United States. Most of them have one thing in common—they became deaf before they had acquired language. A deaf child may see a person's lips move but he cannot relate that movement to sound, nor can he relate it to the written word or visible object. He has no language at all. To put the components of language into a meaningful relationship is the primary mission of the teacher in a school for the deaf. For the deaf child, this teacher is the bridge between his world of silence and the world of sound around him. To a considerable degree, the success with which he reconciles the two worlds depends on the skill and patience of his teacher.

For a number of years there has been an acute shortage of trained academic classroom teachers of the deaf. The situation has grown progressively worse as the number of qualified teachers of the deaf being graduated each year fails to keep pace with the growing demands. Every administrator of special schools or classes for the deaf in the United States is being confronted with the problem of increased enrollment and a dwindling supply of professionally trained teachers of the deaf.

This year, a survey of the need for classroom teachers of the deaf has been made by Mr. Johnston, my predecessor, and Dr. D. Robert Frisina, Director of the Hearing and Speech Center of Gallaudet College in Washington, D.C. I would like to quote several paragraphs from this study and to comment upon some of its findings.

'A number of factors apparently have contributed toward making the teacher shortage critical. The recruitment of teachers in the field of general education has not kept abreast of the needs. Undoubtedly, the need for special teachers of the deaf reflects in part the teacher needs of the nation as a whole. Although the percentage of deaf among the general population of the United States probably is not changing, the actual number of deaf children is likely to be increasing as a result of the increase in the overall population of the United States. New medical discoveries and techniques which tend to decrease the mortality rate also may be contributing to the ncrease in the number of deaf children who otherwise might not have lived prior to such medical advancements. Earlier detection of problems in hearing has resulted in initiating special training at a younger age.'

'Classes for the multiple handicapped deaf also are being established and require additional teachers. A considerable number of teachers of the deaf are employed in Speech and Hearing Clinics, the number of which has grown rapidly since 1945. Finally, the supply of classroom teachers of the deaf has scarcely been sufficient to meet the needs brought about by retirements from the profession for one reason or another.'

The study was undertaken to determine the need for trained academic classroom teachers of the deaf. In order to approximate the supply-demand ratio, some 365 administrators in special schools and classes for deaf children in the United States were contacted. Of this number, 233 replied to specific questions designed to reflect the overall need for teachers during the academic year 1959-60, to provide information concerning past years, and a general question pertaining to the future. Of the 233 educational facilities responding, they represented five categories: Public residential schools. Public day classes. Public day schools. Denominational and private residential schools. Denominational and private day classes.

*FRED D. KNITTLE is Director of Development for the Clarke School for the Deaf, at Northampton, Mass.

The study points out that 516 trained classroom teachers of the deaf were needed in the United States during the 1958-59 school year. To meet this demand, only 118 teachers were graduated from the 22 approved training centers, leaving 111 educational facilities unable to fill their needs.

The year 1959-60 holds no great promise. In June of 1959, 127 teachers in training graduated, but 15 of these were foreign students. This left 112 teachers available to fill 511 vacancies in the United States. Prior to June of 1959, six training centers indicated no trainees enrolled at all.

The future holds an even greater challenge! Sixty-eight percent of the 233 responding indicated that they would require an increase in the number of trained classroom teachers of the deaf due to future expansion. Although three more training centers have been approved and the number of teachers in training to be graduated at the end of the school year has increased to 161, we are far from meeting our teacher requirements. Five centers have no teachers in training even now.

What, then, is the alternative? The problem can be met several ways. First, classes can be, and are, expanded beyond a good teacher-student ratio. Because of the type of almost individualized instruction needed by these young people, this is not advisable. Another alternative is to limit the enrollment of deaf children. With the growing number of deaf children requiring this special education, this would only compound an already serious problem. Another possibility, and I'm afraid one that is being practiced because of necessity, is to employ teachers who are unqualified in this field, and to provide them with "in-service training." Because of the heavy load on present teachers, this also is quite impractical.

The only reasonable answer is to provide such an incentive as to attract many more high-calibre young people to this special educational field. The financial assistance included in this resolution would be a great help in providing incentive to those who normally would not enter the profession because of economic limitation. Through this, and by increasing our own recruiting activities, can this problem be eased.

It was not too many years ago that a deaf child, mute only because he was unable to hear, was forced to walk a path of loneliness, isolation and many times ridicule. But today, provided with specialized education by dedicated and responsible teachers, this same child can become a self-supporting citizen making an effective contribution to a hearing world.

I urge you to help us meet this growing demand for academic classroom teachers of the deaf by favorable action on House Joint Resolution 494.

(This statement was accompanied by copies of the Johnston-Frisina Study)

Your Committees in Action

REFLECTIONS ON EDITORIAL POLICY

Journal of Speech and Hearing Disorders

MARY HUBER*

SOMEWHERE, not long ago, we heard the word "editor" defined as "one who is paid to reject manuscripts," implying, no doubt, that editors, like perhaps, undertakers, would not assume such distasteful responsibilities except for the material benefits therefrom. It has been suggested that our membership would like to know more about how the editorial staffs of our journals operate in the processing of manuscripts for publication. We could not, in the small space allotted for this presentation, give a comprehensive analysis of the complete procedures necessary in the functions of editing and publication. We offer here, however, a few comments and suggestions which may help to clear up some of the questions that perplex many prospective authors.

Fortunately, it is the custom, with most professional journals, to have an editorial board to evaluate manuscripts and assist the editor in selecting those most suitable for publication. Considering the length of time it often takes to process a manuscript, some contributors to the *Journal of Speech and Hearing Disorders* may think that their articles have passed through the hands of every associate editor; this is not likely to be the case. Editors are chosen somewhat for their specialties and also for the fact that they know something about writing, at least, if not editing. The editor leans heavily upon the judgment of the associate editors; in some cases a manuscript is accepted after being submitted to a single associate editor; at other times the manuscript may pass through the hands of several before the final decision of acceptance or rejection is made. Since associate editors are located in all parts of the country and have full-time assignments which have first priority to their attention, the process takes time. It is the responsibility of the associate editor, when he finds that a manuscript has value but needs revision in a number of ways, to correspond directly with the author, offering suggestions for improvement, either in content or style. An author may occasionally disagree with an associate editor's point of view, but as a rule a compromise can be worked out. We do not claim to be infallible, nor do we necessarily rule out controversial issues so long as it is made clear to our less sophisticated readers that there are other points of view on the subject. We recognize the danger of becoming mechanical about a task which must necessarily be highly selective. In the course of a year there are about twice as many manuscripts processed as there is space allotted for publication; hence a rejection does not always mean that the manuscript is entirely unsuitable but that the criticisms presented indicate the manuscript was somewhat less salvable than a number of others from which the editors made their selections.

A mistake that many authors make is to submit a manuscript for consideration to the editor before taking the trouble to put it into proper style for the *JSHD*, their reason being that they prefer not to go to all the trouble unless they can be fairly certain that the article will be published. In the first place, the editor does not consider herself to be a specialist in all phases of our profession and she might, in such instances, discourage an author because the manuscript, on the whole, presents a very poor impression. A paper which has been prepared for a convention address ordinarily requires considerable revision to make it suitable for publication; it is for this reason that we make available to authors our "Information to Contributors" and "Examples of Manuscript Style." When authors ignore these helpful suggestions, they place a heavy burden on associate editors and often unnecessarily delay the processing of their manuscript and the date of publication.

At the beginning of the present editorship it was suggested that, in consideration of the establishment of two separate journals, the *Journal of Speech and Hearing Disorders* and the *Journal of Speech and Hearing Research*, each editor make a statement as to the character of the articles which would henceforth appear in the respective *Journals*. It was then stated that the *Journal of Speech and Hearing Disorders* would be devoted primarily to clinical topics, techniques of evaluation, research which presented significant clinical implications, case studies, treatment and re-education in disorders of speech and hearing. We feel that the emphasis should necessarily be on the practical side and that presentations should contain ideas, suggestions, and techniques of recognized value to conscientious clinicians and educators who look to their professional journals for guidance and enlightenment.

Many members who have significant contributions to make, either in terms of research of successful techniques, hesitate to write for publication because

*Editor of the *Journal of Speech and Hearing Disorders*.

of a recognized or imagined lack of writing skill. Here we would like to suggest the valued and frequent practice of collaboration; "ghost writing" is the term used in more popular writing; it has its advantages in professional circles as well. If a member feels that he can make a valuable contribution to the literature, he may be wise to share the honors therefrom with another who can assist him in making the presentation as attractive as possible instead of forever keeping his talents "under a bushel," so to speak.

Authors are, as a rule, extremely sensitive about their creative efforts; when a manuscript is returned to them by the editor or associate editors with a multitude of suggestions for revision, their reaction may be that the article was probably no good in the first place and so is hardly worth all the trouble to revise it. As a rule, if the editors felt that the manuscript was worthless, the criticisms would not have been made in terms of suggested changes; when a manuscript does not appear to be salvagable, the rejection is frank and to the point. While the editor's policy is to maintain a high quality in the publication, he or she frequently also prevents an author from making a fool of himself, a fact which is seldom appreciated.

Occasionally members encourage specialists in other fields to submit articles for the *JSHD*; this is commendable, particularly if the individual has a real contribution to make in the interests of our profession, which, we must never fail to recognize, is an outgrowth of many related specialties. Such contributions have added much of interest and distinction to our publication. An important criterion, we feel, for selection of manuscripts, is that they contribute something above and beyond that body of knowledge which is part of the academic preparation of most speech and hearing specialists. Authors, some of whom are not trained in our profession, occasionally fail to take into consideration the contributions of earlier authorities and present, however scientific, discerning, and readable, a paper which provides our readers with nothing that is novel, stimulating, or immediately practical.

We would like to draw attention to the section of the *Journal* entitled "Clinical Forum." This department, edited by Miss Esther Herbert, was developed especially for clinicians and public school correctionists who might wish to exchange ideas, techniques, and materials, submit unusual case studies for the interest of other members, or even to solicit help in special problems. It was also felt that this section might provide space in the *Journal* for those who would like to try their hand at a less formal type of writing than is required for the regular articles in the *Journal*. This department, like the *Journal of Speech and Hearing Disorders* itself, only in a more circumscribed way, could provide significant, clinically rich material which should be readily understood by the worker who has little more than basic training in the field. The department can be only as good as you, members and readers, wish to make it; we welcome your contributions and we should like to know if you find it helpful.

It is hoped that this presentation may have cleared up some of the mysteries that surround the editorial functions. Our efforts are as painstaking, efficient, and considerate as time and energy permit; after all, our own reputations are at stake. While we do not stand back of every article that is published, we are responsible to the membership for the general quality and content of our publication.

ASHA-PURDUE—OFFICE OF EDUCATION STUDY

Speech and Hearing Clinicians from Nome to Miami, and from Honolulu to Bangor, will shortly receive a 100-item inquiry into every facet of their professional lives, according to Dr. T. D. Hanley, Coordinator of the ASHA-Purdue, Office of Education Study. Nine work groups submitted hundreds of items for the questionnaire, almost all of them good and valid. The task of final selection proving impossible for the resident staff, multiple forms of the questionnaire, retaining a small core of common items, and sampling dozens of other professional matters in different forms, were prepared. Judging by a 90% return rate in the preliminary pilot survey conducted in Indiana a record return from the nation-wide effort is expected. Members are asked to help assure a maximum return by not only returning their own questionnaires promptly but by urging colleagues to do likewise.

Meanwhile, the resident research staff is engaged in analysis of formal printed material generously provided by state directors of speech and hearing and special education programs. While preliminary indications are that certain information about the profession is to be found in these published materials, such items as limits of supervisory responsibility, job definitions, in-service training, criteria for termination on remedial training are questions touched on in the questionnaires, so a complete picture of public school services is in prospect.

The next major task confronting the investigators is the collection of personal interview data to complement and supplement the questionnaire. Volunteers wishing to participate in this phase of the study are urged to communicate with Dr. T. D. Hanley, Coordinator, Speech and Hearing Clinic, Purdue University, Lafayette, Indiana, very soon.

REVISION OF BY-LAWS

As a result of the changing needs within our Association, the Executive Council of the American Speech and Hearing Association approved three proposed By-Law changes at their recent Convention meeting in November 1959. Ballots were sent to Association members to enable them to consider and vote on each of the three recommended changes. The final results of the election balloting and voting on the three By-Law changes were as follows:

1. A change in the By-Laws was recommended in order to include the Seal of the Corporation. It was approved by the Association members 2,157 to 99 with 51 defective or incomplete ballots not included in the final tabulation.
2. A second change was recommended in order to restrict Associateship to undergraduate students in speech, hearing or tangent areas. The membership approved this change by a vote of 2,073 to 246 with 9 defective or incomplete ballots not included in the final tabulation.
3. A third change was recommended in order to establish a House of State Delegates within the By-Laws. Proposals regarding the selection of delegates, admission to the House of State Delegates, duties, organization and structure of the House of State Delegates and meetings were included within this By-Law change. This recommended By-Law change was approved by the Association members 2,119 to 128 with 52 defective or incomplete ballots which were not included in the final tabulation.

Additional actions were also taken by the Council and reported to the membership at the business meeting held at the Cleveland Convention in 1959. These actions are presently being phrased into proper terminology for final approval by the Council and submission to the membership for their consideration. These changes are in regard to the American Speech and Hearing Foundation and the Committee on Publications.

S.L.B.

BETTER HEARING MONTH

May—1960

BETTER HEARING MONTH, an educational campaign sponsored annually in the month of May by the American Hearing Society, has again been endorsed by the Advertising Council, Inc., of America. This approval, which is given to less than a dozen national health, welfare and character building organizations, assigns BETTER HEARING MONTH to a protected "time zone": May 1-15 for national radio and TV; May 1-31 for general and local promotion. Like other Advertising Council-endorsed campaigns, such as Heart, Cancer and Mental Health, BETTER HEARING MONTH is permitted to solicit national "visibility." This A-C stamp of approval is like sterling on silver . . . it is a guarantee to the networks and their advertisers that "this is a bona fide, professional, ethical, nonprofit organization which merits your support." It says, in effect, "They're O.K., help them."

With this big toe-in-the-door, the American Hearing Society is well on its approved rounds of calls in behalf of BETTER HEARING MONTH for May 1960. As this goes to press it has:

1. Submitted story material for an hour length TV program on the rehabilitation of young adults to one of the national networks;
2. Provided story line on the incidence of hearing loss in preschool children for a picture-and-story feature in a leading Sunday magazine with outlets in 155 major cities;
3. Been promised BHM editorial mention (with mats) in six of the largest monthly magazine publications;
4. Established distribution of network and affiliate radio spots with open-end copy for tie-ins with member agencies of AHS in the local communities;
5. Prepared announcement of Leonard K. Firestone as Honorary National Chairman of BHM;
6. Sent request for President Eisenhower's annual proclamation to the White House.

Clinical and Educational Materials

PUBLICATIONS

The Parent Series of publications should prove to be invaluable materials in the counseling of parents of children with speech handicaps, as well as to provide recommended comprehensive reading simultaneously with or following counseling. Available from the National Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago 12, Illinois.

WHY DID THIS HAVE TO HAPPEN, An Open Letter to Parents, Earl Schenk Miers, Parent Series No. 1, Code E-17, 1957. Price 25 cents. This inspirational "Open Letter" is an account of the author, who writes with understanding insight and personal experience of problems faced by those who are handicapped.

YOUR CHILD'S PLAY, Grace Langdon, Ph.D., Parent Series No. 2, Code E-18, 1957. Price 25 cents. The author, an outstanding authority in child development richly describes in this 25-page booklet, the importance of making play provisions an individual matter. Specific suggestions are given which may be adapted to fit any child, any home and any parent in order to help a child "to be a person other children will accept and enjoy, a person who brings richness to their living, just as they bring it to his."

TOWARD UNDERSTANDING STUTTERING, Wendell Johnson, Ph.D., Parent Series No. 3, Code E-21, 1959. Price 25 cents. This publication is reviewed in the Journal of Speech and Hearing Disorders, February 1960, Vol. 25, Number 1.

HELP FOR YOUR CRIPPLED CHILD—"YOU ARE NOT ALONE," Lawrence J. Linck, Parent Series No. 4, Code E-23, 1959. Price 25 cents. This pamphlet was written as a guide to sources of care and treatment and with the express purpose of helping parents to help themselves and their handicapped children. While the basic responsibility is assumed to be that of the parent, this guide describes the many resources such as professional persons, volunteer workers, friends and other parents who stand ready to help and to give supplementary support in the process of a child's development, care, and adjustment.

BRIGHT PROMISE for your child with Cleft Lip and Palate, Eugene T. McDonald, Ph.D., Parent Series No. 6, Code E-26, 1959. Price 25 cents. This booklet is designed to discuss questions which came to the mind of a father of a child born with a cleft lip and cleft palate and subsequent questions of other parents in group meetings. In so doing, an attempt would be made to dispel the worries, fears and confusion which are common experiences for parents of children with cleft palates, particularly those worries associated with questions concerning causes, repair, speech development, intelligence and the affect of the handicap on personality.

LANGUAGE DISORDERS IN CHILDREN, Nancy E. Wood, Ph.D. 1959, Code E-25. National Society for Crippled Children and Adults, Inc., 2023 West Ogden Ave., Chicago 12, Ill. A monograph adapted from the Seminar for professional personnel "Diagnostic and Therapeutic Approaches to the Aphasic Child." Presented at the Convention of National Society, November 1958, at which Dr. Wood was principal speaker. The information reported in this publication resulted from a single long-term (1952-60) study of children with delayed language and speech development. It includes background and definition, diagnostic approach—differentiating language disorders from other causes of delayed language development, diagnostic implications during therapy and finally, suggestions for therapy.

RECORDING

WE SPEAK THROUGH MUSIC, Sr. Mary Arthur, C.D.P., Ph.D., Director of Speech and Hearing Clinic and Sr. Mary Elaine, C.D.P., M. Music, Associate Professor, Our Lady of the Lake College, San Antonio, Texas, 1959. Publishers, Stanbow Productions, Inc., Valhalla, New York. Three 12" 33 1/3 r.p.m. albums with Song Book are available on approval. The 64 songs have been recorded in a sequence in which a child learns to articulate sounds (Irene Poole Study, *Genetic Development of Articulation of Consonant Sounds in Speech*. Elementary English Review, 2 (1934) .) Songs are divided into two parts. Part I is designed to meet the requirements of children from 3 to 5 years of age. Part II is for children from 5 to 8 years of age. Each song emphasizes a particular consonant sound in its various positions in words and those sounds with which children have the most difficulty are stressed

in singles, in blends and in a greater number of songs than those, which are seldom misarticulated. The content of the songs which relates to family, friends, pets, games, and make believe was chosen on the basis of appeal to young children. Most of the words in the songs were taken from word lists completed by Edward L. Thorndike (*The Teachers Word Book*, New York: Teachers College, Columbia U. 1921) and Henry D. Rinsland (*A Basic Vocabulary of Elementary School Children*, New York. The MacMillan Company 1947.) The meaningful songs, delightfully sung consisting usually of one verse and never more than two should prove motivating and of interest to young children. In addition both words and music are conducive to movement, action, and rhythm, so that the child may combine bodily activity with his speech activities. These new records, with the accompanying manual, have multiple adaptive possibilities for the speech correctionist, the classroom teacher and parent. They could be used advantageously in articulation therapy, for ear training, for the stabilization of new sounds in words and sentences, and for making the transition from the use of the new sounds in words to its use in everyday speech. Primary teachers should find them valuable in attempting to improve the speech of all children in their classrooms as well as in connection with reading readiness and phonetics training. Teachers for the deaf, mentally retarded and aphasic children and others with delayed speech should find *We Speak Through Music* a satisfactory means of stimulating speech development.

EQUIPMENT

EXAMINING THE ORAL SPEECH MECHANISM, executed by William E. Castle with Frederic L. Darley serving as technical consultant. Available through the Bureau of Audio-Visual Instruction, Extension Division, State University of Iowa, Rental $4.50; sale price, $200. Color, 16 mm., 25 minutes. Prepared primarily for orienting the beginning speech pathology and audiology student about this mechanism as it relates to speech problems, this film demonstrates how an oral mechanism examination might be administered effectively when the objective is seeking out physical problems which may affect speech. Illustrations of the types of information sought by performing this examination and many of the reasons for seeking such information are presented. It is largely definitional, pointing up graphically all the parts of the mechanism (the lips, the teeth and jaws, the tongue, the hard palate, the velum and the fauces) and many of the deviations which may occur in any one of them.

REPRINTS

The following reprints are available through the Information Section of The National Society for Crippled Children and Adults.

SOCIAL AND EMOTIONAL DEVELOPMENT IN THE ADOLESCENT CRIPPLED, Lawrence K. Frank, Code A-98, 1951. Price 10 cents. How to understand the crippled Adolescent as a maturing personality who must be helped to feel accepted as a normal individual.

LETTER TO THE PARENT OF A CEREBRAL PALSIED CHILD, Mary Huber, Ph.D., Code A-111, 1952. Price 10 cents. Describes day-to-day home training of cerebral palsied child to aid in speech development.

IF YOUR CHILD HAS A SPEECH PROBLEM, Spencer F. Brown, M.D., 1956, Code Number A-165. Price 10 cents. Suggestions as to treatment of the child with the speech handicap.

A SYSTEM FOR DEVELOPING SPEECH WITH CEREBRAL PALSIED CHILDREN, Harold Westlake, Ph.D., 1951, Code Number D-4. Price 25 cents. Describes psychological, social and physiological readiness and direct training in speech.

UNDERSTANDING YOURSELF AND YOUR CHILD, (Papers from Parent Institute and Seminar, Annual Meeting of Society, 1953) 1955, Code E-14. Price 50 cents. Discussion should lead to a fuller understanding of the crippled child and his relationship to parent, and as part of family and community.

FILM

TELEPHONE USEFUL IN SPEECH THERAPY, described in Rehabilitation Literature, January 1960, Volume XXI No. 1, National Society for Crippled Children and Adults, Inc., 2023 Ogden Ave., Chicago 12, Ill. A special kind of telephone has been found useful in training speech-handicapped children. This teletrainer was originally intended as an aid in teaching phone technics to normal children. A 25-foot cord connects two telephones to a central control box, which supplies a dial tone, busy signal, and the ringing. Children dial a number and talk while classmates listen. They listen to recordings made of their voices.

Readers are urged to contact Mrs. Vivian I. Roe, Department of Speech, Alabama College, Montevallo, Alabama, Associate Editor of CLINICAL AND EDUCATIONAL MATERIALS, if they have information of pertinence to this Department.

Mr. Roy E. Hartbauer is shown using an Allison Audiometer at the Audiology Clinic directed by the Department of Otolaryngology, School of Medicine, College of Medical Evangelists, at the White Memorial Hospital, Los Angeles, California.

Calendar of Professional Events

INTERNATIONAL

July 21-27	Third International Conf. on Medical Electronics, London, England.
July 24-29	Scientific Study of Mental Deficiency Conference, London, England.
August 7-12	World Federation for Mental Health, Edinburgh, Scotland.
August 7-12	International Association of Gerontology, San Francisco, Calif.
August 28-September 2	8th World Congress, International Society for Welfare of Cripples, New York City.
September, 1960	International Symposium for Gen. and Applied Phonetics, Hamburg, Germany.
September 28-October 1	Conf. International Audiology Society, Bonn, Germany.

NATIONAL

April 19-23	Annual Conv., Council for Exceptional Children, Biltmore Hotel, Los Angeles, Calif.
April 20-22	American Academy of Pediatrics, Atlantic City, N. J.
April 25-27	National Academy of Science, Washington, D. C.
May 5-6	Annual Mtg., President's Comm. on Employment of Physically Handicapped, Washington, D. C.
May 6-9	American Psychoanalytic Association, Atlantic City, N. J.
May 9-13	American Psychiatric Association, Atlantic City, N. J.
May 12-14	American Association for Cleft Palate Rehabilitation, Denver, Colo.
June 9-11	Acoustical Society of America, Boston Univ., Providence, R. I.
November 1	**National Conf., Public School Speech and Hearing Therapy Practices and Problems, Los Angeles, Calif.**
November 1-5	**Annual Conv., American Speech and Hearing Association, Los Angeles, Calif.**

Necrology

Leland A. Watson
(1907 - 1960)

LELAND A. WATSON, Founder and President of Maico Electronics, Inc., and President of the Hearing Aid Industry Conference, died in the crash of a commercial airliner on March 17, while en route to Miami to attend the Sixth Reunion of the Pan-American Congress of Oto-rhinolaryngology.

Mr. Watson was a native of Minneapolis where he attended the University of Minnesota. He was a Phi Beta Kappe and won his letter in ice hockey. After graduating from the University with honors, he was awarded a Rhodes scholarship to Oxford University where he studied for three years and earned his Master's degree. While at Oxford Mr. Watson was a member of the championship hockey team which competed in virtually every country in Europe.

In 1933 Lee Watson returned to this country and became associated with the infant hearing aid industry as a dealer. Being the son of a prominent otologist, he became acutely aware of the need for better testing of hearing and rehabilitation of the hard-of-hearing. He founded the Medical Acoustical Instruments Company, (MAICO), in 1937 for the purpose of manufacturing electronic hearing test instruments. Two years later his company began the manufacture of hearing aids as well. He is credited with producing one of the first wearable vacuum tube hearing aids using miniature tubes developed in England.

Among the pioneering developments contributed by Lee Watson were the automatic zero reference level in clinical audiometers, the first fully transistorized hearing aid, and the top-mounted microphone to reduce frictional noises in hearing aids.

He also developed a means for concealing receivers in earrings using plastic tubing for conducting sound to the ear from a receiver worn away from the ear. The first audiometer and the first hearing aid to be accepted by the American Medical Association's Council on Physical Medicine were produced under Mr. Watson's direction.

Mr. Watson was also well-known as the co-author of the book *Hearing Tests and Hearing Instruments* which is still widely used as a text and reference work. In the course of his extensive travels he developed a fluency in several languages and friendships with many who enjoy international reputation in the field of hearing. In this country Mr. Watson was widely known as a result of his appearances at conventions, and as a speaker who expressed himself forthrightly on issues as he regarded them. Leland Watson was a forceful leader in his own field and a significant contributor to the field of Audiology as well. He will be missed by his many friends who have respected and admired him even when they have not always been able to agree with his views.

News and Announcements

Organizational

More than 5,000 representatives of 50 nations are expected to attend the Eighth World Congress of the International Society for the Welfare of Cripples, which will be held in New York City, August 28 to September 2, 1960. "Rehabilitation and World Peace" will be the theme of this first and largest international rehabilitation meeting to be held in the United States. Host organization for the Congress is the National Society for Crippled Children and Adults, Inc. Howard Rusk, M.D., is Congress President, Lawrence J. Linck, Chairman of the Congress Committee, and Dwight D. Eisenhower has accepted the role of Honorary President. On Tuesday, August 30, one section meeting will be devoted to Speech and Hearing. The program for this section is being planned by Wendell Johnson, Ph.D. Topics for other meetings include: Neurological Diseases; Orthopedics; Plastic Surgery; and Rehabilitation for the Aging. Another feature of the Congress will be the scientific and special exhibits which will demonstrate methods, appliances, and equipment used in treating and serving crippled children and adults. Further information is available from: Eighth World Congress Office, Chatham Hotel, 33 East 48th Street, New York 17, New York.

The White House Conference on Children and Youth, which was held in Washington, D.C., March 27-April 2, 1960, has made available to the public those publications which each person attending received as a part of his registration fee. Titles available include: *The Nation's Children,* edited by Eli Ginzberg; *Children in a Changing World;* the *State Reports Digest;* the *National Organizations Digest;* and the *Conference Proceedings.* Any of these may be purchased from the Publications Division, White House Conference, 330 Independence Avenue, S.W., Washington, D.C.

The proceedings of a working conference, "Health Aspects of Hearing Conservation," were published as a supplement to the *Transactions* of the American Academy of Ophthalmology and Otolaryngology in December, 1959. The conference was organized by Aram Glorig, M.D., at the invitation of A. L. Chapman, M.D., Chief of Special Health Services of the United States Public Health Service. Two hundred professional workers attended the conference May 18 and 19, 1959, in Washington, D.C. Workgroups were established for four areas: Early Case Finding; Care of Persons with Impaired Hearing; Habilitation and Rehabilitation; and Training and Research. Recommendations of the workgroups and the conference proceedings are included in this supplement. A limited number of copies of the publication may be obtained free from: Mr. A. E. Harvel, Division of Special Health Services, U. S. Public Health Service, Washington 25, D.C.

The London Conference on Scientific Study of Mental Deficiency, which will meet July 24-29, 1960, was organized as a contribution to the World Mental Health Year. The American Association on Mental Deficiency is one of the sponsors of the conference which will be held at the British Medical Association Headquarters. Subject matter of the conference, which will cover a wide range, wil include: Psychopathy and Behavior Problems; Psychotherapy; Diagnosis; Learning Problems; Epilepsy; Cerebral Palsy, etc. Invited speakers will represent: Holland, Sweden, Turkey, USSR, Germany, France, Denmark, and Belgium, as well as Great Britain and the United States. Details are available from Conference Headquarters, 39 Queen Anne Street, London, W.I.

The American Hearing Society has received eight new audiometers which it will loan to communities throughout the country for use in public school hearing testing programs. Funds for four of the audiometers were raised through contributions of the Juvenile Granges to a "Earn for Ears" project. These boys and girls, who range from 5-14 years in age, contributed their earnings and savings for a three-month period to the fund, which was sufficient to purchase four audiometers. After suitable bidding procedures, four Sonotone 91M audiometers were ordered by the American Hearing Society. Irving Schachtel, president of the Sonotone Corporation, increased the number of audiometers to eight as Sonotone's contribution to the project.

The Hearing Aid Industry Conference reports that the response to its new voluntary Code of Ethics has been positive and immediate. One section of the code deals with the use of ambiguous company names, such as "center" or "institute," which give a false impression of a medical, educational, or research function rather than a commercial one. Although the code of ethics is very specific about the question of "bait" advertisement, no particular emphasis was placed on this section of the 12-page code. It has been reported, however, that a number of dealers have already changed the names of their firms to conform to the new standard. The industry believes that the voluntary code is the best guarantee of ethical service, but it has requested the public or interested organizations to report any questionable practices.

The Instrument Society of America has appointed a committee to compile and publish a comprehensive compendium of current information on all known transducers in use in medicine, industry, etc. A transducer is defined as any device which enables the conversion of a physical, chemical, or biological phenomenon into a signal suitable for recording, analysis, or measurement. Because of the extensive and rapid application of transducers, information about their capabilities and performances appears in a wide variety of scientific and technical journals. Since this information has not been readily available to scientific investigators and designers, duplications, slowed progress, and wasted time have resulted. The first volume of this new study is expected in 1961. Basic source material will be kept current and periodic publication or revised editions is planned.

Institutional

The Sears-Roebuck Foundation has given Gallaudet College a $5,000 grant for production of a brochure describing the advantages of employing deaf college graduates. The brochure will be distributed to potential employers to alert them to the details of the academic preparation of the college trained deaf.

The University of Cincinnati has announced affiliation with the Cincinnati Speech and Hearing Center. A graduate and undergraduate curriculum in speech correction and audiology are planned, with the course work and practicum given at the center. Allan B. Drexler, Ph.D., Director of the Center, has been appointed Clinical Instructor in the Department of Otolaryngology at the College of Medicine, University of Cincinnati.

Readers are urged to contact Mrs. Dorothy D. Craven, Speech Clinic, University of Maryland, College Park, Md., Associate Editor of NEWS AND ANNOUNCEMENTS, if they have information of pertinence to this Department.

The Cleft Palate Institute of Northwestern Dental School, Chicago, announces the fourth annual postgraduate course in prosthetic and orthodontic rehabilitation for the cleft palate patient on May 9 and 10, 1960. The course will include lectures, patient reviews, and demonstrations of orthodontic and speech appliance construction. Enrollment is open to speech pathologists who have a graduate degree and to dentists, but is limited to 20 participants.

A workshop for teaching religion to the deaf, sponsored by the International Catholic Deaf Association, will be held July 25 to August 5, 1960, at DePaul University, Chicago, Illinois. The workshop will be open to professional teachers of the deaf, priests, sisters, and lay teachers. Three hours of undergraduate credit in education may be earned. Further information is available from: Rev. David Walsh, C.Ss.R., St. Alphonsus Center for the Deaf, 1429 Wellington Avenue, Chicago 13, Illinois.

Research Grants and Awards

The Easter Seal Research Foundation has awarded nine new grants and renewed seven other projects for a total of $417,-852. Five of the new grants support studies toward improving rehabilitation centers; the design of building to accommodate the physically handicapped; and to promote the employment of the crippled adult. Three studies more directly related to speech and hearing are:

University of California Medical Center, Dept. of Surgery, San Francisco, $17,513, "Cinefluorographic, photographic, and Sound Tract Studies of the Mechanism of Speech Production in Subjects with Cleft Palate and Subjects with other Anomalies of Velo-Pharyngeal Anatomy and/or Function," Harry M. Blackfield, M.D.

Medical and Health Research Association, New York, $15,720, "Evaluation of Screening, Referral, and Rehabilitation Services for Children with Hearing Problems," Harold Jacobziner, M. D.

University of Wisconsin Medical Center, Madison, Wisconsin, $6,637, "Study of Brain-Injured Patients with Sensory Defects," Francis M. Forster, M. D. and Harry Bowman, M. D.

The University of Chicago, Department of Medicine, Section of Medical Psychology, has been awarded a grant from the Easter Seal Research Foundation. Ward Halstead, Ph.D., will direct an investigation of "The Methodology for Objective Evaluation of Psychometric and Biological Intelligence of Handicapped Children Including Cerebral Palsy."

A research project to develop a "Pictorial Interests Inventory for Use with the Deaf" will be undertaken by Gallaudet College. A $17,440 grant from the Office of Vocational Rehabilitation will sponsor the research which is needed, according to the college, because "the reading ability of many deaf people is not up to the level required by current interests tests."

On Other Fronts

James L. Flanagan, Sc.D., of the Bell Telephone Laboratories, has been appointed Associate Editor of the *Journal of the Acoustical Society of America* for papers on speech communication. Since 1948 much of Dr. Flanagan's research has been aimed toward the efficient transmission of speech information over narrow band-width channels. Problems in acoustic instrumentation, speech production, and perception have also received his attention. He is chairman of the Technical Committee on Speech Communication of the Acoustical Society. Dr. Flanagan succeeds Kenneth N. Stevens, Massachusetts Institute of Technology, who had served as the Associate Editor for speech communication since 1957.

Photographs and citations of 11 new Fellows of the Acoustical Society of America have been published in a recent issue of the *Journal of the Acoustical Society*. Harold L. Barney was recognized "for his researches in the field of speech, and for his development of an improved artificial larnyx to give those who have lost their larynx a more natural sounding voice." George A. Misrahy was recognized "for research in physiological acoustics which led to a better understanding of the physiology and electro-physiology of the inner ear, of hearing impairment, and of the auditory phenomena at the level of the central nervous system."

Necrology

Professor Agostino Gemelli, O.F.M., of the Institute of Psychology and Phonetics, Catholic University, Milan, Italy, died in the late summer of 1959 at the age of 81. Professor Padre Gemelli was known for many and different activities, but his first research was devoted to experimental and psychological phonetics. He was the author of more than 40 publications on phonetics including two in collaboration with John Black, Ph.D., of Ohio State University. Professor Gemelli was the founder of the "Societa Italian di Fonetica, Foniatria, e Audiologia" (Italian Society of Phonetics, Phoniatrics, and Audiology). At the Laboratory of Phonetics of the "Universita Cattolica del S. Cuore," he investigated the physiology of the voice using both electronic and physical means.

According to an obituary prepared by Professor Michele Arslan, Chief of Otolaryngology, Medical School and Hospital, University of Padua, Italy, "it was he who roused us from inaction, who promoted the institution of laboratories, who fostered that tangential but lively activity some of us devote to theoretical and clinical investigations in phoniatrics. . . . He had a modern vision of science whose problems —he always pointed out—must be faced with the aid of the most advanced techniques which the present technological development puts at the researcher's disposal."

SUMMER PROGRAMS

Information concerning the summer programs at the following colleges and universities was received too late for inclusion in the listing in the March issue. The individual listed for each school should be addressed directly for detailed information.

MICHIGAN ST. UNIV.
East Lansing, Mich.
John E. Dietrich, Head, Sp. Dept., (5).

OHIO UNIV., Athens, Ohio
A. C. LaFollette, Ph.D., Sp. and Hrng. Cl., (5, 5).

SOUTHERN CONN. ST. COLL.
New Haven, Conn.
Maryann Peins, Ph.D., Sp. and Hrng. Cent., (6).

SOUTHERN METHODIST UNIV.
Dallas, Texas
Peggy Harrison, Ph.D., Sp. and Hrng. Cl., (6).

STATE UNIV. TEACHERS COLL.
Genesco, N. Y.
Harold B. Starbuck, Ph.D., Sp. and Hrng. Cent., (6).

TULANE UNIV. SCHOOL OF MED.
New Orleans, La.
Jeannette Laguaite, Ph.D., Sp. and Hrng. Cent., (8).

UNIV. OF DENVER
Univ. Park, Denver 10, Colo.
Elwood Murray, Ph.D., School of Sp., (9).

UNIV. OF VERMONT
Burlington, Vermont
Eleanor M. Luse, Ph.D., Sp. and Hrng. Cl., (6).

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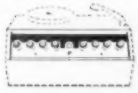

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Forum

COMMENTS ON QUESTIONS SUBMITTED BY MARGARET WHEATON

After reading the article "Some Problems of Relationships Between Speech and Hearing Specialists and Those in the Medical Profession" in the December, 1959 ASHA, Mrs. Margaret Wheaton submitted to the authors three questions, which we consider to be of great significance professionally and entirely pertinent to what we had written. We suggested that these questions and our comments be submitted for publication in ASHA. We prefer the following comments not be considered as "answers." Certainly we are no more able to answer these questions than are many others. Furthermore, it is doubtful that answers can be found that will apply to even a majority of situations; therefore, our comments have to do with our experience in our own particular situation. Perhaps this experience will apply to others.

In commenting generally on the article, Mrs. Wheaton asks her first question in this manner: "All this is fine if you are a Ph.D. But most of us are ordinary therapists with a Bachelor's Degree, possibly a Master's, and with full or pending Basic Certification in ASHA. Maybe we shouldn't try to treat the more serious cases, but if we don't they'll go untreated. Can we, too, talk with the MD as equals?"

This question appears to express what seems to us to be an all too common overevaluation of the significance of the Ph.D. Degree or the Master's Degree—or even Clinical Certification. It seems, also, that the question stems from a misinterpretation that we are all prone to make of the term "equal." Perhaps we would have been wiser not to have used such terminology in our article, because "equal" connotes so many things not pertinent to what we mean in this instance.

It so happens that both the authors of the article have wives who have degrees in home economics. We do not consider ourselves "equals" to our wives in the art of homemaking; and until we begin to suffer seriously from malnutrition, we shall respect our wives' competence as specialists in the field of homemaking. Neither of us would dare instruct our wives how to bake a cake, but neither of us feels "unequal" to our wives as persons. Perhaps some of the answers to the question we are discussing lies in this analogy.

The article pointed out the lack of opportunity that medical education affords to the medical student for anything but a superficial knowledge of disorders of speech and hearing. If the clinician has done a thorough speech and hearing evaluation, using what help and information he needs to clearly understand the problem, he can confidently expect to know more about the nature of the speech or hearing disorder, and the therapy necessary, than the physician. The degree, and the Clinical Certification the clinician holds, may signify something as to the extent of his acquaintance with the literature, and his training and experience; but these do not determine competence, judgment and thoroughness.

The key to this question seems to be that, while the physician will know much more than the speech or hearing specialist about the patient's medical problems, his physical condition, his physiological and anatomical limitations and potentialities; he will not know about the phonetic properties of the speech distortion, the relation of the dysfunction of the organs involved to speech, the specific levels of the various aspects of the individual's verbal performance, and such aspects. These are problems for the speech or hearing specialist; and whether he holds the Ph.D. or the Bachelor's Degree—if he has not gone beyond his limitations—he is the "expert" with respect to this particular area, and as such can discuss it with the physician. As the article pointed out, he gets into trouble only when he approaches the physician as an "equal" in the area of medical problems, or when he expects the physician to know much more about the speech and hearing problem than the physician is likely to know.

The speech clinician described by Mrs. Wheaton can and should talk to the physician, not with a concern about whether or not he is "equal," but with a concern for a patient with a problem that can best be treated by the cooperation of the two specialists rather than either one singly. This is a pooling of information and skill—and if it is done freely and easily and without self-consciousness, or without the need to maintain a position, or to bolster one's ego or to demonstrate the lack of competence of some other specialist, there can be a profitable, cooperative exchange of information.

The second question is as follows: "You mention a careful and adequate speech examination to be reported to the physician. What should the 'ordinary therapist' described above be equipped to do along these lines?" Here again terminology appears to be one of the problems involved in this question. What is our concept of "ordinary therapist?" One wonders at times if it is not such a limited concept that it gives rise to many of the problems discussed in the article. Too often it appears that our concept of "ordinary therapist" is limited to that of a technician whose chief concern is with the manipulation of so-called "speech organs," by the application of a much-used set of devices and procedures—frequently with only a superficial evaluation of the speech problem and little study of the many other aspects of the child.

Perhaps part of the answer to this question is that the speech and hearing examiner, no matter how well trained he is in the field of diagnostic speech and audiology, is not likely to be capable of doing an adequate examination and making adequate report on many of the disorders he will see without a great deal of help. With perhaps a majority of his cases he can gather enough information from his own examination, from school records, a good parent interview, psychological examination, and medical information to make a diagnosis and proceed with therapy with considerable confidence. With a smaller number he will, perhaps, need consultation; at least with his supervising consultant or another clinician. With still a smaller number of cases he will need to make referral for extensive study in a clinic equipped to do the job.

A part of the answer to this question lies, not so much in what the speech clinician does as what he does not do, as so often is the case when he proceeds under the misconception that a speech evaluation and report is a one-man job. The longer one works with a good diagnostic team the more likely he is to reach the somewhat "subversive" conclusion that both school and clinical case loads could be cut drastically if adequate diagnostic study were done on all cases. In the first place, therapy time would be greatly shortened if the clinician had a clearer picture, at the beginning of therapy, what he is working with. In the second place, many cases would not be enrolled in therapy either because of a very poor prognosis or because, with proper help, the problem could be eliminated at home—or, in many instances, by just time alone.

The report to the physician would pretty well take care of itself if the examination were properly done. One suggestion here, however, seems to be pertinent. The clinician's major concern in reporting to the physician, or anyone else, should be to "report." All too frequently the so-called report is a mixture of description, interpretations, impressions, and sometimes feeling on the part of the clinician about the case in question. When the physician, who is looking for descriptive information about a case, gets impressions and feelings

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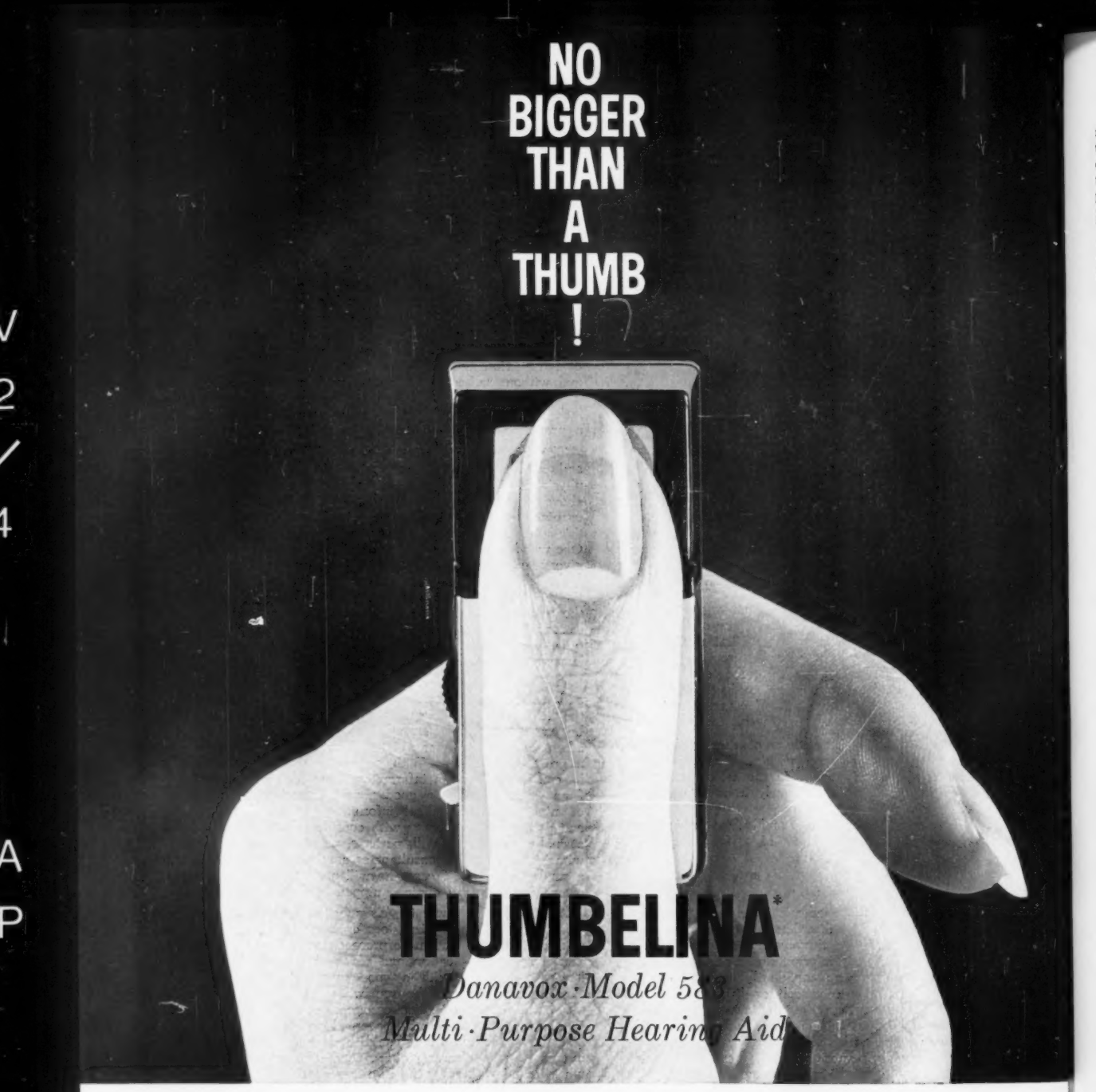

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instead, he learns much about the clinician but little about the case. The art of clear, objective, careful reporting should consciously be studied and practiced by the clinician. After there is adequate description of the case, there is time and place for interpretation. Rarely is there need for offhand impressions and feeling about mother being "overprotective," "anxious," the child being "difficult," and etc. The interpretation, when needed, should be on the basis of the facts involved, shoud stick to the speech or hearing problem, and leave medical, psychological and social interpretations to specialists in those fields.

Finally, the report to the physician should be more than a copy of the results of the speech evaluation. It should be helpful to the physician in his relations with his patient. He doesn't want to know the details of the speech examination, but does want to know its results and the effects of the problem on the child's functioning, as well as prognosis and recommendations for treatment of the speech disorder. If there are specific medical or surgical procedures that the clinician feels would help the speech, he should call the physician and ask his opinion as to the feasibility of such a course, rather than to write such a recommendation into a report and thereby seem to be telling the physician what to do. Another aspect of this situation is how to report to the physician when we have been unable to make a diagnosis of the speech or hearing problem. Perhaps too frequently we feel that we must give him an answer or he will think us incompetent. A report to the physician stating, "I do not know what is wrong" at times, can be as useful information to him as a report giving him a diagnosis.

The "ordinary therapist" can do these things as well as those who do not fall into this category, whoever they may be. The important aspect here is not who the reporter is, but what he does.

The third question asked by Mrs. Wheaton: "Can you define for us which patients can safely be taken on for therapy without a doctor's report and which should have one?" is very interesting—and extremely difficult to comment on. The concept of "report" in the sense used here is important. As the article attempted to explain, the purpose in asking for medical information is not primarily to get a "report" from a physician. All of us have had sad experience in the past of getting nothing useful from a physician when we simply ask for a report. Furthermore, we have found that sending a patient with a speech problem to a physician for a medical examination often is equally unproductive, unless we prepare the way. In the first place, the physician does not know what the speech or hearing specialist needs in the way of information. When he is examining a patient, his approach will be quite different if he knows there is a speech or hearing problem, something of the nature of it, and the kind of information that would be helpful to the speech specialist in diagnosis and possible therapy.

When there is a physician who has followed the child for some time, there will be valuable information that he can give to the speech specialist if he knows what is wanted; but if he does not, he is likely to send a routine comment on the child's immunizations, his minor illnesses, and the general state of his current health. We refer again to the letter in the article that is addressed to the family, with a copy going to the family physician, outlining the kinds of information that will be helpful. We have gone beyond this in many cases, however, by calling the physician and describing more in detail what we are concerned about; or by writing a letter which is more detailed and more specific with respect to this particular problem. We frequently have the experience of a child being referred by a physician who sends us merely a referral or very brief, unimportant information. In such cases we go back to the physician and ask him for the specific information we would like to have. This always includes prenatal, birth, postnatal, and developmental information; not a complete history, but the significant aspects. It is most helpful if we can describe to the physician what the problem appears to be from the application, or from what information we have. Often he can then fit his information into our needs.

With this concept of "report," it would appear that very few, if any, cases should be treated by the speech or hearing specialist without his getting pertinent medical information wherever it is available. At our Center we do not see any children in the speech and hearing clinic without first having what medical information we can get. This is not merely to have a medical referral; actually, in most cases, the referral has been made by someone else. This is to get pertinent medical information that might aid us in doing a more adequate speech, language or hearing evaluation and designing more productive therapy.

It is recognized that there are practical limitations to gathering medical information on all cases, especially in the public schools. Which cases need extensive medical information and which need little will have to be a matter of individual judgment on the part of the careful clinician. It is certain, however, that most problems arising from organic causes should merit the gathering of careful, extensive information including that which the physician will have. Any severe case of delay certainly should not be undertaken without medical information. Those children showing structural abnormalities of any of the speech organs should have medical and dental information that might be significant. These generally would be the problems that the clinician should try to gather adequate medical information on. Beyond that—his own judgment will be his guide. The important consideration here is not so much which cases we do or do not get "reports" on, but our reasons for getting information from the physician. If the idea is no more than to get a physician's signature on something so that we can proceed, it will make little difference whether or not we have "reports" on any of our cases. If, however, we join forces with the physician to help the patient our "which" becomes "why" and the question then answers itself.

Herold Lillywhite
Richard Sleeter
University of Oregon Medical School
Portland, Oregon

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. . . . I was quite concerned over the fact that no announcement was made of the elimination of daily fees for attendance. I feel quite strongly that as many people in the local areas as possible should have the opportunity of attending the convention. The $6.00 fee would seem high. I am thinking particularly of people in associated areas such as psychologists, social workers and guidance persons. I feel quite strongly that the former policy of daily fees should be reinstated so that more local people will be able to attend.

Elizabeth C. MacLearie
Supervisor, Speech and Hearing Therapy
State of Ohio
Columbus, Ohio

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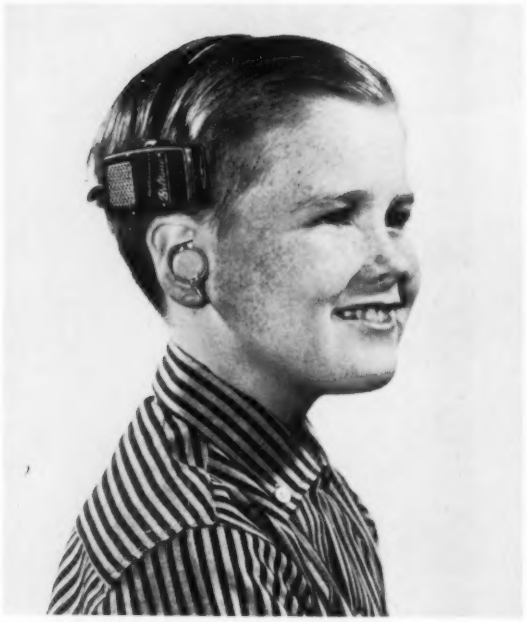

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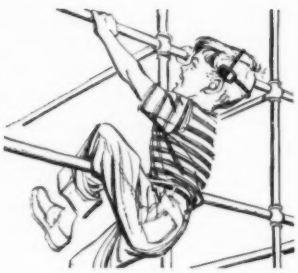

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